NOTICES OF EXEMPT RULEMAKING

The Administrative Procedure Act requires the *Register* publication of the rules adopted by the state's agencies under an exemption from all or part of the Administrative Procedure Act. Some of these rules are exempted by A.R.S. §§ 41-1005 or 41-1057; other rules are exempted by other statutes; rules of the Corporation Commission are exempt from Attorney General review pursuant to a court decision as determined by the Corporation Commission.

NOTICE OF EXEMPT RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

Editor's Note: The following Notice of Exempt Rulemaking was reviewed per Executive Order 2011-05 as issued by Governor Brewer. (See the text of the executive order on page 1889.) The Governor's Office authorized the notice to proceed through the rulemaking process on May 4, 2011.

[R11-135]

PREAMBLE

1. Sections Affected — **Rulemaking Action**
R9-22-217 — Amend

2. The statutory authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):
Authorizing statute: A.R.S. § 36-2903.01

Implementing statute: A.R.S. § 36-2907 as amended by Laws 2011, Ch. 31, § 13 ("the 2011 Act")

3. The proposed effective date of the rules:
October 1, 2011

4. A list of all previous notices published in the *Register* addressing the exempt rule:
Notice of Proposed Exempt Rulemaking: 17 A.A.R. 1518, August 12, 2011

Notice of Public Information: 17 A.A.R. 1723, August 26, 2011

5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name:	Mariaelena Ugarte
Address:	AHCCCS Office of Administrative and Legal Services 701 E. Jefferson St., Mail Drop 6200 Phoenix, AZ 85034
Telephone:	(602) 417-4693
Fax:	(602) 253-9115
E-mail:	AHCCCSrules@azahcccs.gov

6. An explanation of the rule, including the agency's reasons for initiating the rule, including the statutory citation to the exemption from regular rulemaking procedures:
The Governor's Medicaid Reform Plan, as announced on March 15, 2011, includes proposals to reduce nonfederal expenditures for the AHCCCS program by approximately $500 million during state fiscal year 2012. To achieve some of these reductions, the AHCCCS Administration has promulgated rules describing Inpatient limits. These limits also apply to the Federal Emergency Services program, therefore, the Administration is updating rule with cross-references the Inpatient limit rule R9-22-204.

A.R.S. § 36-2907(D) states that AHCCCS shall adopt rules necessary to limit, to the extent possible, the scope, duration and amount of services, that are consistent with federal regulations for the Medicaid program. Those federal regulations require (1) that the State Plan for Medicaid must specify the amount, duration, and scope of each covered service, (2) that services must be sufficient in amount, duration, and scope to reasonably achieve its purpose, and (3) allow each state to place appropriate limits or exclusions on a service based on such criteria as medical necessity or on utilization control procedures. This rule implements the statutory provision consistent with federal regulations.

The limitations or exclusions to services included in the Arizona State Plan for Medicaid as described in this rule will be included in a State Plan Amendment submitted to the federal government in accordance with requirements for the Medicaid program.

At this time, the AHCCCS Administration has clarified that the Inpatient limits are also applicable to the Federal Emergency Service population for adults' age 21 years and older as described within the posted rule R9-22-217 on July 21, 2011.

In Arizona Laws 2011, Ch. 31, § 13, the Legislature authorized the agency to adopt rules, including rules relating to limit, to the extent possible, the scope, duration and amount of services, including maximum limitation for inpatient services.

Arizona Laws 2011, Ch. 31, § 34 authorizes the Administration to adopt rules necessary to implement the AHCCCS program within the available appropriations and exempts the Administration from the formal rulemaking requirements of A.R.S. Title 41, Chapter 6.

Arizona Law 2011, Ch. 31, § 34 requires public notice with an opportunity for public comment of at least 30 days. Public notice of this rulemaking has been accomplished through publication of this rulemaking on the agency web site on July 21, 2011. A supplemental notice also appeared in the *Arizona Administrative Register* in advance of the close of the comment period. In addition, notice was directed to those individuals who, prior to this proposed rulemaking have notified the agency of their desire to receive such notices directly pursuant to A.R.S. § 36-2903.01(B)(6).

7. A reference to any study relevant to the rule that the agency reviewed and either relied on or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study and other supporting material:

No studies were relied upon for the implementation of this rulemaking, but analysis of the member utilization of Inpatient services reported through claims and encounters for dates of service during SFY 2010, has assisted the AHCCCS Administration in arriving at the proposed limitations. Prior to proposing this rule, AHCCCS reviewed historical information regarding utilization of the services limited by the rule. Based on that review, AHCCCS determined that approximately 96% of utilizing members would remain unaffected when these limitations are implemented.

8. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

9. The summary of the economic, small business, and consumer impact:

AHCCCS estimates that the limitations on inpatient days will reduce total expenditures by approximately $64 million in combined state and federal funds for the last three quarters of the state fiscal year ending June 30, 2012 and approximately $85 million for the following state fiscal year. It is difficult to estimate with any degree of certainty whether, or to what extent, this will result in less care being provided. As set forth in rule, in many instances health care providers are permitted to charge patients for services provided but not paid for by AHCCCS as a result of these limitations. It is equally difficult to estimate with any degree of certainty to what extent this rulemaking may result in health care providers rendering care without adequate compensation from sources other than AHCCCS.

10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):

The Administration initially proposed a revision to rule R9-22-210 to exclude the use of CPT code 99281 for facility services provided in an emergency department. As a result of feedback from the Center for Medicare and Medicaid Services (CMS), the Administration will not proceed with exclusion of CPT code 99281. Therefore, the Administration has limited the rulemaking to the change provided under R9-22-217 which cross references the promulgated Inpatient Limit rule R9-22-204 effective October 1, 2011.

11. A summary of the comments made regarding the rule and the agency response to them:

The public comment period closed at 5:00 p.m. on August 21, 2011. No comments were submitted for this rulemaking.

12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

Not applicable

13. Incorporations by reference and their location in the rules:

None

14. Was this rule previously made as an emergency rule? If so, please indicate the *Register* citation:

No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 2. SCOPE OF SERVICES

Section
R9-22-217. Services Included in the Federal Emergency Services Program

ARTICLE 2. SCOPE OF SERVICES

R9-22-217. Services Included in the Federal Emergency Services Program

A. Definition. For the purposes of this Section, an emergency medical or behavioral health condition for ~~a~~ an FES member means a medical condition or a behavioral health condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:
1. Placing the member's health in serious jeopardy,
2. Serious impairment to bodily functions,
3. Serious dysfunction of any bodily organ or part, or
4. Serious physical harm to another person.

B. Services. "Emergency services for a FES member" mean those medical or behavioral health services provided for the treatment of an emergency condition. Emergency services include outpatient dialysis services for an FES member with End Stage Renal Disease (ESRD) where a treating physician has certified for the month in which services are received that in the physician's opinion the absence of receiving dialysis at least three times per week would reasonably be expected to result in:
1. Placing the member's health in serious jeopardy, or
2. Serious impairment of bodily function, or
3. Serious dysfunction of a bodily organ or part.

C. Covered services. Services are considered emergency services if all of the criteria specified in subsection (A) are satisfied at the time the services are rendered. The Administration shall determine whether an emergency condition exists on a case-by-case basis.

D. Prior authorization. A provider is not required to obtain prior authorization for emergency services for FES members. Prior authorization for outpatient dialysis services is met when the treating physician has completed and signed a monthly certification as described in subsection (B).

E. Services rendered through the Federal Emergency Services Program are subject to all exclusions and limitation on services in this Article including but not limited to the limitations on inpatient hospital services in R9-22-204.

NOTICE OF EXEMPT RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

Editor's Note: The following Notice of Exempt Rulemaking was reviewed per Executive Order 2011-05 as issued by Governor Brewer. (See the text of the executive order on page 1889.) The Governor's Office authorized the notice to proceed through the rulemaking process on May 4, 2011.

[R11-137]

PREAMBLE

1.	**Sections Affected**	**Rulemaking Action**
	R9-22-1205	Amend

2. The statutory authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statute: A.R.S. § 36-2903.01

Implementing statute: A.R.S. § 36-2907 as amended by Laws 2011, Ch. 31, § 13 ("the 2011 Act")

3. The proposed effective date of the rules:
October 1, 2011

4. A list of all previous notices published in the *Register* addressing the exempt rule:
Notice of Proposed Exempt Rulemaking: 17 A.A.R. 1522, August 12, 2011

5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name:	Mariaelena Ugarte
Address:	AHCCCS Office of Administrative and Legal Services 701 E. Jefferson St., Mail Drop 6200 Phoenix, AZ 85034
Telephone:	(602) 417-4693
Fax:	(602) 253-9115
E-mail:	AHCCCSrules@azahcccs.gov

6. An explanation of the rule, including the agency's reasons for initiating the rule, including the statutory citation to the exemption from regular rulemaking procedures:

The Governor's Medicaid Reform Plan, as announced on March 15, 2011, includes proposals to reduce nonfederal expenditures for the AHCCCS program by approximately $500 million during state fiscal year 2012. To achieve some of these reductions, the AHCCCS Administration is promulgating limitations to covered respite services.

At this time, the AHCCCS Administration is promulgating an approximate 15 percent reduction in the annual limit for respite hours. Respite services are provided to members receiving Behavioral Health services in an Acute care setting and to members in the ALTCS program. The respites services are not delineated under the state plan, however, they are a covered service under the 1115 Waiver.

In Arizona Laws 2011, Ch. 31, § 13, the Legislature authorized the agency to adopt rules under A.R.S. § 36-2907(D), including rules relating to limit, to the extent possible, the scope, duration and amount of services, including maximum limitation for inpatient services.

Arizona Laws 2011, Ch. 31, § 34 authorizes the Administration to adopt rules necessary to implement the AHCCCS program within the available appropriations and exempts the Administration from the formal rulemaking requirements of A.R.S. Title 41, Chapter 6.

Arizona Law 2011, Ch. 31, § 34, requires public notice with an opportunity for public comment of at least 30 days. Public notice of this rulemaking was accomplished through publication of this rulemaking on the agency web site on July 21, 2011. A supplemental notice also appeared in the *Arizona Administrative Register* in advance of the close of the comment period. In addition, notice was directed to those individuals who, prior to this proposed rulemaking have notified the agency of their desire to receive such notices directly under A.R.S. § 36-2903.01(B)(6).

7. A reference to any study relevant to the rule that the agency reviewed and either relied on or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study and other supporting material:

No studies were relied upon for the implementation of this rulemaking, but analysis of the member utilization of respite services reported through claims and encounters for dates of service during SFY 2010, has assisted the AHCCCS Administration in arriving at the proposed limitations. Prior to promulgating this rule, AHCCCS reviewed historical information regarding utilization of the services limited by the rule. Based on that review, AHCCCS determined that at least 75 percent of utilizing members would remain unaffected if these limitations are implemented.

8. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:
Not applicable

9. The summary of the economic, small business, and consumer impact:
AHCCCS estimates that the limitations on respite hours will reduce total expenditures by approximately $5.2 million in combined state and federal funds for the state fiscal year 2012.

10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):
Not applicable

11. A summary of the comments made regarding the rule and the agency response to them:
The following public comments were received by the close of the comment period, 5:00 p.m. on August 21, 2011:

The Arizona Legislature has directed the AHCCCS Administration to establish a program within legislative appropriation. Due to the state's severe budget crisis, the Legislature has not appropriated sufficient funds to maintain the benefit at the current level. Reducing respite hours involves difficult decisions which the Administration realizes will

have significant impacts on the lives of some Arizona residents. The reduction of respite hours is one of several steps the Administration must take to provide benefits within appropriated funds. The AHCCCS Administration has previously limited or eliminated optional services and continues to explore other service limitations. In addition, the AHCCCS Administration has previously reduced provider rates, and made changes to eligibility.

Numb:	Date/ Commenter:	Comment:	Response:
1.	07/23/11 Pam Rowe Director Caring Connections	If respite care is to be very nimimal or nonexistant I believe that the state had best be prepared to open and staff (big money) more children home type facilities. Along with that our juvenile system is going to grow majorly. People are going to think twice before becoming foster parents. *(sic)* Would we be better off with respite support systems now or juvenile halls being at capacity?	The AHCCCS Administration initially proposed a reduction to 360 hours of respite care. After considering the public's input the Administration implemented a much more limited reduction to 600 hours of respite care per year. The Administration understands that a reduction in services may be challenging, but we believe that 600 hours per year – 50 hours per month – will allow for families to receive needed respite.
2.	07/24/11 Jessica Nelson Caregiver Caring Connections	I believe if the respite hours a year is cut in half it will not only hurt the kids but thier families also. By thier parents not being able to work as much as they are now which will impact thier lives financially. It will also effect alot of providers as well by even putting them out of jobs. We can still work with the kids if the respite hours are just cut down to 600 a year. *(sic)*	See above response.
3.	07/24/11 Shellie Echternach Direct Care Provider Caring Connections	I feel that these services are absolutly necessary to the families we provide them to. most of the kids i work with are in foster care. they need to use the respite programs for many reasons. the main thing i see is these kids come from pretty tuff situations when they are placed in foster care so act out because they don't know what else to do. the need a break from worrying about whats going on in the home. the foster parents need a break from the behaviors. the families we provide respite services that are not foster families, are usually at the point were if the child does not get this break something bad is gonna happen. with out the respite house many of these children are gonna end up in the juvenile detention center, gangs or something. please do not cut the funding to our program. *(sic)*	See above response.

4.	08/09/11 Joyce Hoie Director Raising Special Kids	In keeping with a family-centered approach to services, it would be helpful to avoid a situation where respite services alone are being changed or considered outside of the ISP process, and without the context of planning and coordinating the full range of needed services for the child. Although the plan year, starting October 1st, offers a precise date for administrative implementation, it may pose significant problems for large numbers of families and Support Coordinators to thoughtfully plan and prepare for a respite reduction within a short period of time. By using the ISP year, rather than the plan year, it maintains respite services within the complement of other service arrangements and offers a more efficient and family-friendly implementation. In a planned service reduction that is likely to be somewhat complex and difficult for both families and service providers, it is suggested that AHCCCS consider this as a necessary and prudent accommodation.	Although an ISP year was considered, DES Division of Developmental Disabilities supported the respite change with the benefit year of 10/01 through 09/30 time-frame.

12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

Not applicable

13. Incorporations by reference and their location in the rules:

None

14. Was this rule previously made as an emergency rule? If so, please indicate the *Register* citation:

No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 12. BEHAVIORAL HEALTH SERVICES

Section
R9-22-1205. Scope and Coverage of Behavioral Health Services

ARTICLE 12. BEHAVIORAL HEALTH SERVICES

R9-22-1205. Scope and Coverage of Behavioral Health Services

A. Inpatient behavioral health services. The following inpatient services are covered subject to the limitations and exclusions in this Article.
1. Covered inpatient behavioral health services include all behavioral health services, medical detoxification, accommodations and staffing, supplies, and equipment, if the service is provided under the direction of a physician in a Medicare-certified:
   a. General acute care hospital, or
   b. Inpatient psychiatric hospital.
2. Inpatient service limitations:
   a. Inpatient services, other than emergency services specified in this Section, are not covered unless prior authorized.
   b. Inpatient services and room and board are reimbursed on a per diem basis. The per diem rate includes all services, except the following licensed or certified providers may bill independently for services:
      i. A licensed psychiatrist,
      ii. A certified psychiatric nurse practitioner,

iii. A licensed physician assistant,
iv. A licensed psychologist,
v. A licensed clinical social worker,
vi. A licensed marriage and family therapist,
vii. A licensed professional counselor,
viii. A licensed independent substance abuse counselor, and
ix. A behavioral health medical practitioner.

c. A member age 21 through 64 is eligible for behavioral health services provided in a hospital listed in subsection (A)(1)(b) that meets the criteria for an IMD up to 30 days per admission and no more than 60 days per ~~contract~~ benefit year as allowed under the Administration's Section 1115 Waiver with CMS.

B. Level 1 residential treatment center services. Services provided in a Level 1 residential treatment center as defined in A.A.C. R9-20-101 are covered subject to the limitations and exclusions under this Article.

1. Level 1 residential treatment center services are not covered unless provided under the direction of a licensed physician in a licensed Level 1 residential treatment center accredited by an AHCCCS-approved accrediting body as specified in contract.
2. Covered residential treatment center services include room and board and treatment services for behavioral health and substance abuse conditions.
3. Residential treatment center service limitations.
   a. Services are not covered unless prior authorized, except for emergency services as specified in this Section.
   b. Services are reimbursed on a per diem basis. The per diem rate includes all services, except the following licensed or certified providers may bill independently for services:
      i. A licensed psychiatrist,
      ii. A certified psychiatric nurse practitioner,
      iii. A licensed physician assistant,
      iv. A licensed psychologist,
      v. A licensed clinical social worker,
      vi. A licensed marriage and family therapist,
      vii. A licensed professional counselor,
      viii. A licensed independent substance abuse counselor, and
      ix. A behavioral health medical practitioner.
4. The following may be billed independently if prescribed by a provider as specified in this Section who is operating within the scope of practice:
   a. Laboratory services,
   b. Radiology services, and
   c. Psychotropic medication.

C. Covered Level 1 sub-acute agency services. Services provided in a Level 1 sub-acute agency as defined in A.A.C. R9-20-101 are covered subject to the limitations and exclusions under this Article.

1. Level 1 sub-acute agency services are not covered unless provided under the direction of a licensed physician in a licensed Level 1 sub-acute agency that is accredited by an AHCCCS-approved accrediting body as specified in contract.
2. Covered ~~level~~ Level 1 sub-acute agency services include room and board and treatment services for behavioral health and substance abuse conditions.
3. Services are reimbursed on a per diem basis. The per diem rate includes all services, except the following licensed or certified providers may bill independently for services:
   a. A licensed psychiatrist,
   b. A certified psychiatric nurse practitioner,
   c. A licensed physician assistant,
   d. A licensed psychologist,
   e. A licensed clinical social worker,
   f. A licensed marriage and family therapist,
   g. A licensed professional counselor,
   h. A licensed independent substance abuse counselor, and
   i. A behavioral health medical practitioner.
4. The following may be billed independently if prescribed by a provider specified in this Section who is operating within the scope of practice:
   a. Laboratory services,
   b. Radiology services, and
   c. Psychotropic medication.
5. A member age 21 through 64 is eligible for behavioral health services provided in a ~~level~~ Level 1 sub-acute agency

that meets the criteria for an IMD for up to 30 days per admission and no more than 60 days per ~~contract~~ benefit year as allowed under the Administration's Section 1115 Waiver with CMS. These limitations do not apply to a member under age 21 or age 65 or over.

D. Level 2 behavioral health residential agency services. Services provided in a ~~level~~ Level 2 behavioral health residential agency are covered subject to the limitations and exclusions in this Article.
1. Level 2 behavioral health residential agency services are not covered unless provided by a licensed Level 2 behavioral health residential agency as defined in A.A.C. R9-20-101.
2. Covered services include all services except room and board.
3. The following licensed or certified providers may bill independently for services:
   a. A licensed psychiatrist,
   b. A certified psychiatric nurse practitioner,
   c. A licensed physician assistant,
   d. A licensed psychologist,
   e. A licensed clinical social worker,
   f. A licensed marriage and family therapist,
   g. A licensed professional counselor,
   h. A licensed independent substance abuse counselor, and
   i. A behavioral health medical practitioner.

E. Level 3 behavioral health residential agency services. Services provided in a licensed Level 3 behavioral health residential agency as defined in A.A.C. R9-20-101 are covered subject to the limitations and exclusions under this Article.
1. Level 3 behavioral health residential agency services are not covered unless provided by a licensed Level 3 behavioral health residential agency.
2. Covered services include all non-prescription drugs as defined in A.R.S. § 32-1901, non-customized medical supplies, and clinical supervision of the ~~level~~ Level 3 behavioral health residential agency staff. Room and board are not covered services.
3. The following licensed and certified providers may bill independently for services:
   a. A licensed psychiatrist,
   b. A certified psychiatric nurse practitioner,
   c. A licensed physician assistant,
   d. A licensed psychologist,
   e. A licensed clinical social worker,
   f. A licensed marriage and family therapist,
   g. A licensed professional counselor,
   h. A licensed independent substance abuse counselor, and
   i. A behavioral health medical practitioner.

F. Partial care. Partial care services are covered subject to the limitations and exclusions in this Article.
1. Partial care services are not covered unless provided by a licensed and AHCCCS-registered behavioral health agency that provides a regularly scheduled day program of individual member, group, or family activities that are designed to improve the ability of the member to function in the community. Partial care services include basic, therapeutic, and medical day programs.
2. Partial care services. Educational services that are therapeutic and are included in the member's behavioral health treatment plan are included in per diem reimbursement for partial care services.

G. Outpatient services. Outpatient services are covered subject to the limitations and exclusions in this Article.
1. Outpatient services include the following:
   a. Screening provided by a behavioral health professional or a behavioral health technician as defined in R9-22-1201;
   b. A behavioral health evaluation provided by a behavioral health professional or a behavioral health technician;
   c. Counseling including individual therapy, group, and family therapy provided by a behavioral health professional or a behavioral health technician;
   d. Behavior management services as defined in R9-22-1201; and
   e. Psychosocial rehabilitation services as defined in R9-22-102.
2. Outpatient service limitations.
   a. The following licensed or certified providers may bill independently for outpatient services:
      i. A licensed psychiatrist~~,~~;
      ii. A certified psychiatric nurse practitioner~~,~~;
      iii. A licensed physician assistant as defined in R9-22-1201~~,~~;
      iv. A licensed psychologist~~,~~;
      v. A licensed clinical social worker~~,~~;
      vi. A licensed professional counselor~~,~~;

vii. A licensed marriage and family therapist~~,~~;
viii. A licensed independent substance abuse counselor~~,~~;
ix. A behavioral health medical practitioner; and
x. An outpatient clinic or a Level IV transitional agency licensed under 9 A.A.C. 20, Article 1, that is an AHCCCS-registered provider.

b. A behavioral health practitioner not specified in ~~subsection~~ subsections (G)(2)(a)(i) through (G)(2)(a)(x), who is contracted with or employed by an AHCCCS-registered behavioral health agency shall not bill independently.

H. Emergency behavioral health services are covered subject to the limitations and exclusions under this Article. In order to be covered, behavioral health services shall be provided by qualified service providers under R9-22-1206. ADHS/DBHS shall ensure that emergency behavioral health services are available 24 hours per day, seven days per week in each GSA for an emergency behavioral health condition for a non-FES member as defined in R9-22-102.

I. Other covered behavioral health services. Other covered behavioral health services include:
1. Case management as defined in R9-22-1201;
2. Laboratory and radiology services for behavioral health diagnosis and medication management;
3. Psychotropic medication and related medication;
4. Monitoring, administration, and adjustment for psychotropic medication and related medications;
5. Respite care as described within subsection (K);
6. Behavioral health therapeutic home care services provided by a RBHA in a professional foster home defined in 6 A.A.C. 5, Article 58 or in a behavioral health adult therapeutic home as defined in 9 A.A.C. 20, Article 1;
7. Personal care services, including assistance with daily living skills and tasks, homemaking, bathing, dressing, food preparation, oral hygiene, self-administration of medications, and monitoring of the behavioral health recipient's condition and functioning level provided by a licensed and AHCCCS-registered behavioral health agency or a behavioral health professional, behavioral health technician, or behavioral health paraprofessional as defined in 9 A.A.C. 20, Article 1; and
8. Other support services to maintain or increase the member's self-sufficiency and ability to live outside an institution.

J. Transportation services. Transportation services are covered under R9-22-211.

K. Limited Behavioral Health services. Respite services are limited to no more than 600 hours per benefit year.

NOTICE OF EXEMPT RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ARIZONA LONG-TERM CARE SYSTEM

Editor's Note: The following Notice of Exempt Rulemaking was reviewed per Executive Order 2011-05 as issued by Governor Brewer. (See the text of the executive order on page 1889.) The Governor's Office authorized the notice to proceed through the rulemaking process on May 4, 2011.

[R11-136]

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R9-28-204	Amend
R9-28-205	Amend

2. The statutory authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statute: A.R.S. § 36-2903.01

Implementing statute: A.R.S. § 36-2907 as amended by Laws 2011, Ch. 31, § 13 ("the 2011 Act")

3. The proposed effective date of the rules:

October 1, 2011

4. A list of all previous notices published in the *Register* addressing the exempt rule:

Notice of Proposed Exempt Rulemaking: 17 A.A.R. 1526, August 12, 2011

5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Mariaelena Ugarte

Address: AHCCCS

Office of Administrative and Legal Services
701 E. Jefferson St., Mail Drop 6200
Phoenix, AZ 85034

Telephone: (602) 417-4693

Fax: (602) 253-9115

E-mail: AHCCCSrules@azahcccs.gov

6. An explanation of the rule, including the agency's reasons for initiating the rule, including the statutory citation to the exemption from regular rulemaking procedures:

The Governor's Medicaid Reform Plan, as announced on March 15, 2011, includes proposals to reduce nonfederal expenditures for the AHCCCS program by approximately $500 million during state fiscal year 2012. To achieve some of these reductions, the AHCCCS Administration is promulgating limitations to respite services.

At this time, the AHCCCS Administration is promulgating an approximate 15 percent reduction in the annual limit for respite hours. Respite services are provided to members receiving Behavioral Health services in an Acute care setting and to members in the ALTCS program. The respites services are not delineated under the state plan, however, they are a covered service under the 1115 Waiver.

In Arizona Laws 2011, Ch. 31, § 13, the Legislature authorized the agency to adopt rules under A.R.S. § 36-2907(D), including rules to limit, to the extent possible, the scope, duration and amount of services, including maximum limitation for inpatient services.

Arizona Laws 2011, Ch. 31, § 34 authorizes the Administration to adopt rules necessary to implement the AHCCCS program within the available appropriations and exempts the Administration from the formal rulemaking requirements of A.R.S. Title 41, Chapter 6.

Arizona Law 2011, Ch. 31, § 34, requires public notice with an opportunity for public comment of at least 30 days. Public notice of this rulemaking was accomplished through publication of this rulemaking on the agency web site on July 21, 2011. A supplemental notice also appeared in the *Arizona Administrative Register* in advance of the close of the comment period. In addition, notice was directed to those individuals who, prior to this proposed rulemaking have notified the agency of their desire to receive such notices directly under A.R.S. § 36-2903.01(B)(6).

7. A reference to any study relevant to the rule that the agency reviewed and either relied on or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study and other supporting material:

No studies were relied upon for the implementation of this rulemaking, but analysis of the member utilization of respite services reported through claims and encounters for dates of service during SFY 2010, has assisted the AHCCCS Administration in arriving at the limitations. Prior to promulgating this rule, AHCCCS reviewed historical information regarding utilization of the services limited by the rule. Based on that review, AHCCCS determined that at least 75 percent of utilizing members would remain unaffected if these limitations are implemented.

8. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

9. The summary of the economic, small business, and consumer impact:

AHCCCS estimates that the limitations on respite hours will reduce total expenditures by approximately $5.2 million in combined state and federal funds for the state fiscal year 2012.

10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):

Not applicable

11. A summary of the comments made regarding the rule and the agency response to them:

The following public comments were received by the close of the comment period, 5:00 p.m. on August 21, 2011:

The Arizona Legislature has directed the AHCCCS Administration to establish a program within legislative appropriation. Due to the state's severe budget crisis, the Legislature has not appropriated sufficient funds to maintain the benefit at the current level. Reducing respite hours involves difficult decisions which the Administration realizes will have significant impacts on the lives of some Arizona residents. The reduction of respite hours is one of several steps the Administration must take to provide benefits within appropriated funds. The AHCCCS Administration has previously limited or eliminated optional services and continues to explore other service limitations. In addition, the AHCCCS Administration has previously reduced provider rates, and made changes to eligibility.

Numb:	Date/ Commenter:	Comment:	Response:
1.	07/23/11 Pam Rowe Director Caring Connections	If respite care is to be very nimimal or nonexistant I believe that the state had best be prepared to open and staff (big money) more children home type facilities. Along with that our juvenile system is going to grow majorly. People are going to think twice before becoming foster parents. *(sic)* Would we be better off with respite support systems now or juvenile halls being at capacity?	The AHCCCS Administration initially proposed a reduction to 360 hours of respite care. After considering the public's input the Administration implemented a much more limited reduction to 600 hours of respite care per year. The Administration understands that a reduction in services may be challenging, but we believe that 600 hours per year – 50 hours per month – will allow for families to receive needed respite.
2.	07/24/11 Jessica Nelson Caregiver Caring Connections	I believe if the respite hours a year is cut in half it will not only hurt the kids but thier families also. By thier parents not being able to work as much as they are now which will impact thier lives financially. It will also effect alot of providers as well by even putting them out of jobs. We can still work with the kids if the respite hours are just cut down to 600 a year. *(sic)*	See above response.
3.	07/24/11 Shellie Echternach Direct Care Provider Caring Connections	I feel that these services are absolutly necessary to the families we provide them to. most of the kids i work with are in foster care. they need to use the respite programs for many reasons. the main thing i see is these kids come from pretty tuff situations when they are placed in foster care so act out because they don't know what else to do. the need a break from worrying about whats going on in the home. the foster parents need a break from the behaviors. the families we provide respite services that are not foster families, are usually at the point were if the child does not get this break something bad is gonna happen. with out the respite house many of these children are gonna end up in the juvenile detention center, gangs or something. please do not cut the funding to our program. *(sic)*	See above response.

4.	08/09/11 Joyce Hoie Director Raising Special Kids	In keeping with a family-centered approach to services, it would be helpful to avoid a situation where respite services alone are being changed or considered outside of the ISP process, and without the context of planning and coordinating the full range of needed services for the child. Although the plan year, starting October 1st, offers a precise date for administrative implementation, it may pose significant problems for large numbers of families and Support Coordinators to thoughtfully plan and prepare for a respite reduction within a short period of time. By using the ISP year, rather than the plan year, it maintains respite services within the complement of other service arrangements and offers a more efficient and family-friendly implementation. In a planned service reduction that is likely to be somewhat complex and difficult for both families and service providers, it is suggested that AHCCCS consider this as a necessary and prudent accommodation.	Although an ISP year was considered, DES Department of Developmental Disabilities supported the respite change with the benefit year of 10/01 through 09/30 time-frame.

12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

Not applicable

13. Incorporations by reference and their location in the rules:

None

14. Was this rule previously made as an emergency rule? If so, please indicate the *Register* citation:

No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ARIZONA LONG-TERM CARE SYSTEM

ARTICLE 2. COVERED SERVICES

Section
R9-28-204. Institutional Services
R9-28-205. Home and Community Based Services (HCBS)

ARTICLE 2. COVERED SERVICES

R9-28-204. Institutional Services

A. Institutional services are provided in:
1. A NF;
2. An ICF-MR; or
3. A facility identified in R9-28-1105(A)(1)(b), (B), or (C).

B. The Administration and a contractor shall include the following services in the per diem rate for a facility listed in subsection (A):
1. Nursing care services;
2. Rehabilitative services prescribed as a maintenance regimen;
3. Restorative services, such as range of motion;
4. Social services;
5. Nutritional and dietary services;
6. Recreational therapies and activities;

7. Medical supplies and non-customized durable medical equipment under 9 A.A.C. 22, Article 2;
8. Overall management and evaluation of a member's care plan;
9. Observation and assessment of a member's changing condition;
10. Room and board services, including supporting services such as food and food preparation, personal laundry, and housekeeping;
11. Non-prescription and stock pharmaceuticals; and
~~12. Respite care services not to exceed 30 days per contract year.~~
12. Respite care services not to exceed 600 hours per benefit year.

C. Each facility listed in subsection (A) is responsible for coordinating the delivery of at least the following auxiliary services:
1. Under 9 A.A.C. 22, Article 2:
   a. Attending physician, practitioner, and primary care provider services;
   b. Pharmaceutical services;
   c. Diagnostic services under A.A.C. R9-22-208;
   d. Emergency medical services; and
   e. Emergency and medically necessary transportation services.
2. Therapy services under R9-28-206.

D. Limitations. The following limitations apply:
1. A private room in a NF, ICF-MR, or facility identified in R9-28-1105(A)(1)(b), (B), or (C) is covered only if:
   a. The member or has a medical condition that requires isolation, and
   b. The member's primary care provider or attending physician provides written authorization;
2. Each ICF-MR shall meet the standards in A.R.S. § 36-2939(B)(1), and in 42 CFR 483, Subpart I, February 28, 1992, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments;
3. Bed hold days as authorized by the Administration or its designee for a fee-for-service provider shall meet the following criteria:
   a. Short-term hospitalization leave for a member age 21 and over is limited to 12 days per AHCCCS ~~contract year~~ benefit year, and is available if a member is admitted to a hospital for a short stay. After the short-term hospitalization, the member is returned to the institutional facility from which leave is taken, and to the same bed if the level of care required can be provided in that bed; and
   b. Therapeutic leave for a member age 21 and older is limited to nine days per AHCCCS ~~contract year~~ benefit year. A physician order is required for therapeutic leave from the facility for one or more overnight stays to enhance psycho-social interaction, or as a trial basis for discharge planning. After the therapeutic leave, the member is returned to the same bed within the institutional facility;
   c. Therapeutic leave and short-term hospitalization leave are limited to any combination of 21 days per ~~contract year~~ benefit year for a member under age 21;
4. The Administration or a contractor shall cover services that are not part of a per diem rate but are ALTCS covered services included in this Article, and deemed necessary by a member's case manager or the case manager's designee if:
   a. The services are ordered by the member's primary care provider~~;~~, and
   b. The services are specified in a case management plan under R9-28-510;
5. A member age 21 through 64 is eligible for behavioral health services provided in a facility under subsection (A)(3) that has more than 16 beds, for up to 30 days per admission and no more than 60 days per ~~contract year~~ benefit year as allowed under the Administration's Section 1115 Waiver with CMS and except as specified by 42 CFR 441.151, May 22, 2001, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments; and
6. The limitations in subsection (D)(5) do not apply to a member:
   a. Under age 21 or age 65 or over, or
   b. In a facility with 16 beds or less.

R9-28-205. Home and Community Based Services (HCBS)

A. Subject to the availability of federal funds, HCBS are covered services if provided to a member residing in the member's own home or an alternative residential setting. Room and board services are not covered in a HCBS setting.

B. The case manager shall authorize and specify in a case management plan any additions, deletions, or changes in home and community based services provided to a member or in accordance with R9-28-510.

C. Home and community based services include the following:
1. Home health services provided on a part-time or intermittent basis. These services include:
   a. Nursing care;
   b. Home health aide;
   c. Medical supplies, equipment, and appliances;

d. Physical therapy;
e. Occupational therapy;
f. Respiratory therapy; and
g. Speech and audiology services;
2. Private duty nursing services;
3. Medical supplies and durable medical equipment, including customized DME, as described in 9 A.A.C. 22, Article 2;
4. Transportation services to obtain covered medically necessary services;
5. Adult day health services provided to a member in an adult day health care facility licensed under 9 A.A.C. 10, Article 5, including:
   a. Supervision of activities specified in the member's care plan;
   b. Personal care;
   c. Personal living skills training;
   d. Meals and health monitoring;
   e. Preventive, therapeutic, and restorative health related services; and
   f. Behavioral health services, provided either directly or through referral, if medically necessary;
6. Personal care services;
7. Homemaker services;
8. Home delivered meals, that provide at least one-third of the recommended dietary allowance, for a member who does not have a developmental disability under A.R.S. § 36-551;
~~9. Respite care services for no more than 720 hours per contract year;~~
9. Respite care services for no more than 600 hours per benefit year;
10. Habilitation services including:
    a. Physical therapy~~;~~,
    b. Occupational therapy~~;~~,
    c. Speech and audiology services~~;~~,
    d. Training in independent living~~;~~,
    e. Special development skills that are unique to the member~~;~~,
    f. Sensory-motor development~~;~~,
    g. Behavior intervention~~;~~, and
    h. Orientation and mobility training;
11. Developmentally disabled day care provided in a group setting during a portion of a 24-hour period, including:
    a. Supervision of activities specified in the member's care plan~~;~~,
    b. Personal care~~;~~,
    c. Activities of daily living skills training~~;~~, and
    d. Habilitation services; and
12. Supported employment services provided to a member in the ALTCS transitional program under R9-28-306 who is developmentally disabled under A.R.S. § 36-551.